STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

May 3, 2006

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs)
and Community Mental Health Services Programs (CMHSPs)

FROM: Irene Kazieczko, Director
Bureau of Community Mental Health Services
Mental Health and Substance Abuse Administration

SUBJECT: FY 2006/2007 Mental Health Block Grant Request for Proposals (RFP)
Proposal Application Deadline: June 26, 2006

Attached for your careful review and response is the Community Mental Health Block Grant RFP for adult services. These Community Mental Health Services Block Grant funds are targeted for development of new high quality and culturally relevant community-based services for adults with serious mental illness, as specified in the Michigan of Department of Community Health (MDCH) plan approved by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). CMHSPs are invited to apply for funds to eliminate barriers to recovery that it has identified in its system of care, working in conjunction with consumers and other stakeholders. The total funding available under this RFP is approximately $3 million.

Direct service initiatives funded under this initiative will be for two years, beginning October 1, 2006. A maximum of $100,000 in bock grant funds is available for the first fiscal year and a maximum of $50,000, with an equal contribution from the CMHSP, is available for the second year. CMHSPs must commit to continuation of the proposed services.

Training only or one-time purchases for consumer-run programs may request a maximum of $75,000 in block grant funds for the fiscal year beginning October 1, 2006.

Funding is available for one CMHSP to provide for statewide Clubhouse training. There is $75,000 available for one project for one year beginning October 1, 2006.

Review criteria are included in the RFP.

Also, under this RFP, PIHPs may voluntarily apply to implement the adult evidence-based practice, Family Psychoeducation or Co-occurring Disorders: Integrated Dual Disorders Treatment, for which it did not apply previously. For such applications, the PIHP must use the instructions, forms, funding amounts, and all requirements contained in the Mental Health System Transformation Practice Improvement Infrastructure Development Community Mental Health Block Grant Request for Applications, which was issued May 23, 2005 and is available electronically at the MDCH web site.

Only CMHSPs and PIHPs are eligible to submit proposals in response to this RFP. A program person and a budget person at the CMHSP or PIHP, who are knowledgeable about the proposal and able to make changes if needed, must be identified on the face sheet.

An **informational meeting** for CMHSP and PIHP staff interested in responding to this RFP is scheduled for **Thursday, May 25, 2006, from 1:00 to 4:00 p.m.**, in the Capitol View Building, Conference Rooms A and B, located at 201 Townsend Street, in Lansing (see Attachment J for driving directions). We strongly encourage your participation in this meeting. We recommend that one program person and one budget person from each agency attend. For those unable to travel to Lansing (and for additional staff from each agency), there will be conference call-in availability. Please dial 1-866-230-1124; when prompted enter the following passcode: 7858886. Those desiring to participate by phone should contact Theresa Randleman at Randlemant@michigan.gov, and a copy of the power point presentation will be e-mailed prior to the meeting to allow participants to follow-along. A summary of questions and answers from the meeting will be compiled and posted on the MDCH website following the meeting.

If you have a current block grant project that was accepted as a two-year proposal (including the Practice Improvement Initiatives), do not respond to this RFP for those projects. A separate request for second year budgets and work plans for those projects will be sent to you in June. Remember that second year funding is contingent on satisfactory performance during the current year and on the availability of funds.

Questions regarding this RFP should be directed to the specialist identified for each program area. Please immediately share this RFP with your program and financial staff.

Attachments

cc: Patrick Barrie
Mark Kielhorn
Judy Webb
Patricia Degnan
Karen Cashen

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES
DIVISION OF PROGRAM DEVELOPMENT, CONSULTATION, & CONTRACTS

COMMUNITY MENTAL HEALTH BLOCK GRANT REQUEST FOR PROPOSALS - ADULT SERVICES

FY2006/2007
ONE-TIME ONLY FUNDING
SUBMISSION DUE DATE: JUNE 26, 2006

Purpose

The Michigan Department of Community Health (MDCH) is making available Community Mental Health Block Grant funding to Community Mental Health Services Programs (CMHSPs) to continue the transformation of the mental health system into one that is firmly based in the belief in recovery. CMHSPs must organize around the complexities and needs of people with serious mental illness. This Request for Proposals (RFP) requires applicant CMHSPs to look at its current system of care, identify barriers to people achieving and maintaining recovery, and propose how it will fill the identified gaps. The goal is for people to live satisfying, hopeful, and contributing lives.

Funding Amount Available and Contract Period

It is expected that total funding of approximately $3 million will be available for new projects proposed in response to this RFP. All direct service proposals must be submitted for a two-year period. There is no limit as to the number of proposals that can be submitted.

CMHSP REGIONAL COMPETITIVE PROPOSALS

The maximum block grant funding amount available per direct service project for the first year, October 1, 2006 through September 30, 2007, is $100,000. For the second year, October 1, 2007 through September 30, 2008, the CMHSP must commit other public funding it manages to the project; this amount must equal 50% or more of the total project budget. A maximum of $50,000 in block grant funds will be available for the second year of direct service projects. Second year funding for two-year projects will be contingent upon satisfactory progress achieved during the first year as well as the availability of funds.

Proposals for training purposes or for one-time assistance for consumer-run programs may be submitted for one year, October 1, 2006 through September 30, 2007. A maximum of $75,000 in block grant funds may be requested for these projects; generally such requests are a much smaller amount. CMHSP financial participation in these budgets is encouraged

CMHSP STATEWIDE COMPETITIVE PROPOSAL FOR CLUBHOUSE TRAINING

This RFP also includes the opportunity for CMHSPs to apply for a contract to make training and technical assistance available to Michigan clubhouses. Up to $75,000 in block grant funds is available for one year of funding.

PIHP EVIDENCE-BASED PRACTICE OPPORTUNITY

The May 23, 2005, Mental Health Systems Transformation Practice Improvement Infrastructure Development Request for Proposals allowed Prepaid Inpatient Health Plans (PIHPs) to apply for block grant funds to establish Improving Practices Leaderships Teams and to implement one or both of two evidence-based practices for adults. All PIHPs currently have contracts that include Family Psychoeducation and/or Co-occurring Disorders: Integrated Dual Disorders Treatment. (Requests for second year work plans and budgets for these current projects will be requested in a separate correspondence.)

PIHPs that would like to begin implementation of the practice for which they are not currently funded may apply for two years of block grant funding for the period of October 1, 2006 through September 30, 2008. For this type of application, use the directions, forms, and requirements of the May 23, 2005, RFP, which is available on the MDCH web site at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health, click on Reports and Proposals. A maximum of $140,000 over the two-year period is available for these projects.

All proposals are due June 26, 2006.

CMHSP Required Steps in the Application Process - Overall

Describe the CMHSP system of care for adults with serious mental illness (SMI).

Identify gaps that are preventing adult individuals with serious mental illness from meeting their recovery goals.

Describe how these gaps were identified, such as CMHSP needs assessment, Improving Practices Leadership Team work, Consumer Advisory Group, focus groups, satisfaction surveys, performance indicator review, other data review, and/or any other methods. Specifically describe how consumers were involved in the identification.

CMHSP Required Steps in the Application Process – Each Proposal

List which gap(s) the CMHSP would like to address with block grant funds, how the gap(s) will be filled, and the specific outcome(s) the CMHSP plans to achieve. Examples of outcome(s) are more consumers in supported employment, more consumers in independent living situations, more consumers diverted from jail, etc. The planned outcomes must all relate to consumers achieving their recovery goals.

Proposals submitted by CMHSPs who are part of an affiliation must address how this proposal fits into the larger work of the PIHP to assist consumers in achieving recovery.

Workplans must be very specific about what outcomes are desired, what is going to be done to achieve those outcomes, whom is going to do it, and how the outcomes will be measured and reported.

The CMHSP, in each of its proposal(s), must address how other local pertinent community agencies will be involved in the proposed activity. Addressing the complex needs of adults with serious mental illness is best done within an organized network of community agencies which each have roles in these individual's ability to achieve their recovery goals.

Further, CMHSPs are encouraged to include, within each proposal, as many program components and as many specialized approaches as are needed to increase opportunities for recovery. The cultural needs of the specific population(s) targeted in each proposal must be addressed.

The face sheet (Attachment A) contains lists of both program areas and target populations. This year CMHSPs are requested to check as many categories as apply to each proposal. For staff assignment purposes, it will assist us if you highlight which program or population area you consider most important in your proposal.

Program Areas:

Advance Directives
Anti-Stigma
Assertive Community Treatment (ACT)
Case Management
Clubhouse Programs
Consumer Run, Delivered, or Directed Initiatives
Co-Occurring Disorders: Integrated Dual Disorder Treatment (IDDT)
Cultural Competence
Family Psychoeducation
Jail Diversion
Mental Health Clinical Skills Development
Peer Support Specialists
Person-Centered Planning
Recovery
Self-Determination
Supported Employment
Supported Housing
Other (specify)

At times a project may be designed for one, or more, specific target population. These block grant funds must be used for adults with serious mental illness. Examples of subsets of adults with SMI who may be addressed with these funds are listed below. Please indicate on the face

sheet (Attachment A) which specific population(s) are targeted by the project if the population is more specific than adults with SMI.

Adults with Co-Occurring Substance Disorders
Adults with Dementia
Older Adults
People with a History of Trauma
People who are Homeless
People who are Members of a Special Population (specify)
Residents of Rural Areas
Other (specify)

Continuation

The CMHSP must agree to continue direct service projects funded under this RFP after the grant period. Each proposal must address how the elements of the project will be continued at the end of the block grant funding period. For example, a service may be designed to take the place of a less successful service, which should be identified in the proposal. Or the project may be continued with funds saved through administrative efficiencies.

Proposal Reviews

MDCH is inviting one or more consumer of mental health services to serve on each of its proposal review panels.

Target Population

Funding provided under this RFP must be used for adults with serious mental illness (SMI). CMHSPs are encouraged to use it to improve services for adults with SMI who also have co-occurring substance disorders.

Use of Block Grant Funds

Consistent with federal direction and state transformation activities, Community Mental Health Block grant funds are to be used for activities designed to improve the system of care by promoting recovery. Transformational activities include the provision of evidence-based practices and innovative and promising practices, and the promotion of consumer-driven mental health care. All activities must be built around and consistent with person-centered planning principles and practices. Consumers must have an informed choice regarding their service(s).

Federal mental health block grant funds may not be used to supplant existing mental health funding. It may not be used to fund Medicaid approved services for Medicaid recipients.

Federal authorizing legislation specifies that these funds may not be used to:

(1) provide inpatient services;
(2) make cash payments to intended recipients of mental health services (e.g., stipends, rent payments, utility arrearages, etc.);
(3) purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or
(5) provide financial assistance to any entity other than a public or nonprofit private entity.

MDCH contracts require that any service or activity funded in whole or in part with this funding be delivered in a smoke-free facility or environment.

In addition, this RFP emphasizes the mental health block grant's emphasis upon service provision, and the following restrictions are also included:

(6) no vehicle purchases or leases, no automobile insurance, and
(7) no administrative or indirect expenses.

Proposal Requirements

The CMHSP must submit:

- One Proposal Planning Summary for CMHSP regional competitive proposals. The Proposal Planning Summary is included as Attachment C.1.

- A proposal face sheet for each project request. The face sheet is included as RFP Attachment A.

- A Narrative and Work Plan for each project request, which is included as Attachment C.1, that addresses the full project period and specifies goals, measurable objectives, and concrete activities that will be achieved during each quarter. Assure that the project narrative addresses all of the Review Criteria and proposal requirements contained in this RFP (October 1, 2006 through September 30, 2007).

- A Program Budget Summary and Program Budget Cost Detail. MDCH forms 385 and 386 are contained in Attachment B and the most current versions are accessible from the MDCH website at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health, click on Reports and Proposals).

- A Program Budget Narrative, attached to the budget, which explains expenditures and provides rationale.

The following additional information must be included in proposals for two-year projects:

- A Narrative and Work Plan that addresses the full project period and specifies goals, measurable objectives and concrete activities that will be achieved during each quarter of the proposed second year (October 1, 2007 through September 30, 2008).

- A Program Budget Summary and Program Budget Cost Detail for the second year of the proposed project period and a composite Budget Summary for the two-year period.

- A Program Budget Narrative, attached to the budget, which explains expenditures and provides rationale.

Submission Method and Due Date

All proposals must be submitted electronically by the CMHSP to Karen Cashen, Adult Block Grant Coordinator, at cashenk@michigan.gov no later than **5:00 p.m.** on **June 26, 2006**. Hard copy submissions will not be accepted. The proposal face sheet (Attachment A), with the CMHSP director's original signature, should be mailed to:

Karen Cashen, Adult Block Grant Coordinator
Department of Community Health
Bureau of Community Mental Health Services
320 S. Walnut, 5th Floor
Lansing, MI 48913

Proposal face sheets must also be received by the due date listed above. Signatures other than the CMHSP director will not be accepted. If you have general questions about the RFP, please contact Karen at (517) 335-5934 or at the e-mail address listed above.

Contract Requirement

For each block grant funded project, the CMHSP will be required to submit, with the final narrative report, a one-page paper summarizing the results of the project. These short summaries will be shared with all CMHSPs and PIHPs for the purpose of possible replication in other parts of the state. The summary must include contact information for the person at the CMHSP who can provide additional information and materials related to the project.

Review Criteria for Proposals Submitted in Response to this Request

1. The process used to identify gaps in the system of care for adults with serious mental illness included primary consumers and shows understanding of what is needed in order for adults with serious mental illness to achieve and maintain recovery. The proposal is for development of services or interagency system change that goes beyond basic contract requirements. The applicant provides a description of how the results of the project will be shared with the department for possible dissemination throughout the state. The proposal addresses a priority sub-population group or type of intervention that

is consistent with the RFP. It includes a description of need, provides data to support evidence of the need and rationale for why current efforts have been insufficient to address the concern. It demonstrates the applicant is knowledgeable about other efforts to address the identified need. The proposal clearly demonstrates that the intervention is an enhancement, replication, new approach or innovation, not continuation or substitution of a current intervention or source of funding (e.g., cost-shifting). It describes how the proposed intervention is different from current resource or program capacity (**20%**).

2. The proposal reflects the belief in recovery as the basis of its work. It addresses the values of Michigan's public health system to promote recovery and wellness; reduce stigma; facilitate access; seek support arrangements that facilitate independence, personal responsibility and full participation in community life; promote consumer choice; maximize least restrictive opportunities for community alternatives; and increase opportunities for employment. The proposal describes and includes evidence of consumer involvement, collaboration or support in developing, implementing and monitoring the project. Proposals that involve collaboration with consumers, other professionals or community organizations include letters of support that specify the nature of partners' contributions (**10%**).

3 The proposal demonstrates organizational capacity to carry out the proposal. It includes evidence of consumer participation in planning the project and in carrying it out. It includes evidence of project personnel who are knowledgeable about recovery, the target population, proposed intervention and who have prior experience in working with the target population. Position descriptions and/or resumes of key project personnel are included. Examples are provided of other successful projects the applicant has carried out to expand or enhance services for the identified population. The proposal and budget demonstrate that sufficient staff resources will be allocated to the project (**10%**).

4. The proposal includes a Project Work Plan that provides clear goal statements, measurable objectives and activities. It includes time lines by which specific objectives and activities will be achieved, for each quarter of the contract period (**10%**).

5. The proposal includes an evaluation plan that involves consumers and provides a clear description of proposed outcomes that address one or more of the MDCH priorities, the number of people who will be impacted and specific changes that are expected to occur in the target population, program or system as the result of the intervention. The evaluation plan includes:

    - Clearly defined goals and objectives that specify *who* is the target for change (i.e., consumers, family caregivers or staff), *what* to change, and described expected *differences* in terms of choices, quality of services or quality of life that consumers and their caregivers may experience as the result of receiving services delivered by this initiative.

- A description of proposed outcomes that are clearly defined, relate to the goals and objectives stated in the work plan, and measure things the organization can change.

- A description of the methods that will be used to evaluate the impact of the intervention, the types of data that will be collected to demonstrate the outcomes and the process by which the data will be analyzed, reported and disseminated **(20%)**.

6. The proposal demonstrates commitment by the CMHSP to the initiative. For all applications other than time limited projects such as a one-time only training event, evidence of commitment is reflected by the level of CMHSP funds directed to the project and inclusion of a specific written plan for continuation which identifies specific funding sources to be used once mental health block grant funding ends. For CMHSPs that previously received block grant funding, evidence of demonstrated commitment will also consider the extent to which previously funded mental health block grant initiatives have remained in place **(15%)**.

7. The proposal addresses the departmental priority for designated rural county system and service development for adults with serious mental illness. It demonstrates integration of the remaining review criteria and clearly demonstrates how the proposal will enhance the current system **(5%)**.

8. The proposed budget and budget narrative demonstrate the level of funding requested is reasonable to achieve the proposed outcomes. Proposed costs are aligned with project objectives, personnel needs and other resources required to complete project activities. Line item costs are specified and reasonable **(10%)**.

RFP by Program Areas

ADVANCE DIRECTIVES

Colleen Jasper (517) 373-1255 jasper@michigan.gov

The Estates and Protected Individuals Code, P.A. 386 of 1998, MCL 700.5501 - 700.5520 was amended by Act 532 of 2004 with immediate effect as of January 3, 2005. This Michigan statute allows a "patient" to designate a "patient advocate" and grant to them the authority to make mental health treatment decisions should the patient, at some future time, be determined to lack the capacity to do so for themselves. MDCH has developed forms and instructions on the drafting of a "psychiatric advance directive" consistent with this new legislation.

Advance Directives need to be part of the choices offered during one's Person-Centered Planning Process. Initiatives pertaining to training, education, and support of Advance Directives may be submitted. Consumers need to be involved in all training and distribution of materials on Advance Directives so that the educational atmosphere is grounded in concrete, realistic, and understandable communications to other consumers. Applicants must describe how

the training audience will be targeted, how the training will be implemented, and how the information is to be communicated to consumers by consumer trainers. The role of the staff in this initiative will be to assist consumers in preparation, audience location, training implementation, and follow-up.

ANTI-STIGMA

Colleen Jasper (517) 373-1255 jasper@michigan.gov

Stigma is the number one barrier to recovery. Stigma has many forms and exists widely in both systems and the community. The best way to fight stigma is through interpersonal connections. In other words, hearing the voices and stories of individuals who have directly experienced mental health problems is the best way to change attitudes about mental illness. Initiatives that involve primary consumers who can provide a realistic viewpoint of mental illness are essential to fighting stigma. The full participation of consumers in creating, developing, and implementing this type of initiative is vital. Active involvement of consumers fighting stigma is also essential in helping consumers in the development of their own self-esteem and recovery. Fighting stigma can be very creative and inspiring for consumers as they develop their own leadership skills.

Education of both the system and the community can be done through training sponsored by primary consumers and through creative approaches like support groups, plays, publications, artwork, open forums, open gatherings, etc. Anti-stigma projects can include both visual and language mediums. The involvement of consumers in the completion of proposals is essential and needs to be documented. Consumers should also be hired for key positions within the initiatives. Sustainability of the project should also be included.

ASSERTIVE COMMUNITY TREATMENT

Alyson Rush (517) 335-0250 rusha@michigan.gov

Michigan is currently involved in a significant effort to enhance the fidelity of the existing and previously implemented evidence-based practices (Supported Employment and ACT) by incorporating them into the continuous quality improvement processes at the agency and state level. This process has been enhanced for ACT teams and sponsoring agencies through a private grant that: 1) evaluated the current ACT fidelity to the model in Michigan, 2) made recommendations toward improvement, and 3) created a Field Guide for use by ACT teams and administrators that will: a) survey current fidelity, b) assist staff in making a plan to correct deviations from model fidelity, and c) determine how to implement the plan. The Field Guide is divided into individual components that allow teams to identify and work on each identified component as needed. Training on use of the Field Guide will be offered multiple times at multiple locations (times, dates and locations will be available soon) and technical assistance will also be available.

Proposals that enhance employment activities, educational supports, community integration, and leisure activities for consumers receiving ACT services, or address other system gaps, are

encouraged. Proposals must include how the project will improve administrative support on the ACT model, efforts to develop cooperative and collaborative agreements for service coordination by ACT teams, staffing and responsibility for treatment services, and support for greater model fidelity with particular attention to in vivo contacts.

ACT teams that desire project funding for peer advocates may apply under the category "Peer Support Specialists."

In addition to block grant funding availability under this RFP for ACT service improvement, ACT-specific training is offered at no cost to all ACT teams in Michigan through the Federal Mental Health Block Grant; ACT specific training is a requirement of the current Medicaid Provider Manual. Agencies and teams receive training information and registration materials provided through the Assertive Community Treatment Association (ACTA) and can find it on the website at www.actassociation.org. Participation for a specified number of registrants for each training will be funded for members of Michigan ACT teams by the MDCH through block grant funds. Additional spaces, as well as spaces for those who are not members of Michigan ACT teams, may be available on a fee-for-training basis. Many of the trainings offer continuing educational credits. Training materials and refreshments are provided, as is lunch for all-day sessions; transportation is not included in the training and must be provided through the individual agency.

CASE MANAGEMENT

Pam Werner (517) 335-4078 wernerp@michigan.gov

MDCH will support projects that improve the ability and capacity for case managers to assist consumers in attaining goals as identified in the person-centered planning process.

CLUBHOUSE PROGRAMS

Su Min Oh (517) 241-2957 ohs@michigan.gov

Statewide Clubhouse Training

Proposals are requested for innovative ideas for working with all of Michigan's clubhouses to support recovery, promote and secure employment, member leadership and to improve the quality of services provided in clubhouses. One project will be funded. The CMHSP that receives the funding is required to provide training opportunities for all of Michigan's 47 clubhouses. Proposals must include:

- Training opportunities that promote employment opportunities for clubhouse members
- Training opportunities that promote member leadership
- Training opportunities that promote recovery, empowerment, and community inclusion
- Training opportunities that strengthen the work-ordered day in clubhouses
- Training opportunities that support implementing outcome evaluation

It is expected that each training opportunity will be at no cost, or at a minimal cost, for consumers. The proposal must include evidence of consumer involvement, collaboration or support in developing, implementing and monitoring the project. Review criteria contained in this RFP will be used except that, for this project only, identification of the gap being filled is not necessary.

Up to $75,000 in block grant funds is available for one project for one year only beginning October 1, 2006.

Improving Employment Outcomes

One way of measuring effective clubhouse programs is to examine the number of individuals who are receiving employment services and supports. Employment is a guaranteed right of membership. Assistance in moving members toward full-time employment is needed. Proposals are requested for innovative and creative initiatives to enhance the employment opportunities for clubhouse members. Proposals must address evidence of long-term support for employment. Initiatives must include a benefits planning component so that consumers have information about how work activity will impact their ability to maintain benefits. The proposal must provide background information on how many people the clubhouse serves, the percentage of individuals who were in an employment situation in the past year, what the desired outcomes are and a plan to achieve them.

Clubhouse Long-Term Housing Supports

Clubhouse members living in adult foster care may be living in residential environments that provide limited opportunities to lead a self-determined life. This initiative will target persons currently living in adult foster care and wishing to live independently or with roommates of their own choosing. Through the development of a clubhouse housing unit, members and staff will provide assistance with transition issues, locating housing, furnishings, etc., and provide long-term support for members living independently in the community. Block grant funds cannot be used to subsidize rent or security deposits. Anticipated outcomes may include increased activity of the clubhouse program through the development of a housing unit, increase in the number of members living independently/decrease the number of persons living in dependent (foster) care, and/or increased consumer satisfaction and quality of life.

ICCD Clubhouse Training

First priority for this training will be given to new clubhouse programs or new managers of existing clubhouse programs. This training group must include: 1) the clubhouse manager, 2) one clubhouse staff, 3) one clubhouse member, and 4) CMHSP administrator/supervisor attending the third week. The block grant award covers the fixed tuition and lodging cost of $4,800 and $1,500 toward transportation and meals related to the training. Funding support over and above the block grant award is the responsibility of the CMHSP. Block grant funds cannot be used for clubhouse members or staff that have already participated in block grant funded training. The proposal should indicate the target date and location for their training. Available training dates can be found at www.iccd.org.

CONSUMER RUN, DELIVERED, OR DIRECTED INITIATIVES

Michael Jennings (517) 335-0126 jennings@michigan.gov

Drop-In Program Development or Enhancement

Proposals targeted at enhancement of existing drop-in centers, or the development of new drop-in initiatives where interest and the ability to promote consumer independence and growth are indicated will be considered. Proposals must identify and explain how gaps in the system of care are preventing consumers with serious mental illness from achieving their goal of recovery. If proposals for the development of transportation supports and maintenance, and the provision of support of current consumer programs in the area of equipment, computer training, furniture, and supplies that will enhance the facility are submitted, the proposal must address how these services, activities or items will fill identified gaps and what specific outcomes can be expected, documented and replicated to other areas of the state. Please note that the MDCH contract requires that any service or activity funded in whole or in part with this funding be delivered in a smoke-free facility or environment. All proposals submitted will be required to document that this provision has been met and that a process for monitoring is in place and enforced.

Proposals under this program are intended to be a partnership between the CMHSP and the consumer run drop-ins. Proposals should reflect that partnership by showing a collaborative development of proposals, sharing of budget information, narrative program implementation, and by supplying a sub-agreement or sharing of the grant award contract when awards are made. Proposals should show that both the CMHSP and the consumer groups are equally involved in the total preparation and implementation of any grant initiatives.

Proposals under this program area should be able to demonstrate through the proposal submissions, quarterly narrative progress reports, and the evaluation plan that the intended intervention helps address the values of the public mental health system to reduce stigma, promote recovery, facilitate independence, personal responsibility, and allows for full participation in community life, promotes consumer choice, and maximized the opportunity for consumer autonomy and peer directed and run service alternatives. It is the intent that block grant support in this area can demonstrate outcomes which support systems transformation and consumer recovery that is the goal of the block grant effort. Evaluation of proposals should reflect the goals and objectives of the project and how they fit into a system transformation.

Consumer Run, Delivered or Directed Innovations and Replications

Proposals targeted at the development of innovative, new consumer-run, delivered or directed initiatives are encouraged, such as Project Stay, person-centered planning within a drop-in center setting, peer case management support, and statewide resource development.

Additional information regarding consumer-run programs can be obtained at the websites on recovery noted in this RFP and at *Consumer Operated Services Program: Multi-site Research Initiative* www.cstprogram.org

Please note that it is expected that all proposals directed toward consumer-run initiatives address all of the review criteria contained in this RFP. Purchase of equipment, furniture, supplies, computer training, etc., require addressing each of the review criteria for funding along with the primary requirements of identifying gaps and specifying outcomes related to systems transformation and assisting consumers to achieve and maintain recovery.

CO-OCCURRING DISORDERS: INTEGRATED DUAL DISORDER TREATMENT (COD:IDDT)

Tison Thomas (517) 241-2616 thomasti@michigan.gov

Mental illness and substance disorders affect almost all areas of a person's life and functioning. Consumers and their families have a right to information about effective treatments, areas where evidence-based practice exist, and have the right to access effective services. As an evidence-based practice, IDDT emphasizes the treatment of both mental illness and substance disorders by the same team of clinicians in the same location at the same time. Programs that use this treatment model share the common value of shared decision-making, embracing the view that clients with co-occurring disorders are capable of making decisions about their own goals and the management of their illness in the recovery process.

This section is divided into two parts. The first section is targeted for those PIHPs/CMHSPs where the PIHP is already receiving block grant funding for IDDT implementation and seeks assistance in enhancing aspects of the model. The second section is for those PIHPs that would like to initiate the Integrated Treatment for Mental Health and Substance Disorders beginning October 1, 2006.

COD:IDDT Program Enhancement

The implementation of this practice requires improvement in several organizational and treatment characteristics. Implementing the IDDT model requires changes in the system. The System Transformation Practice Improvement Infrastructure Development Block Grant Request for Applications (RFA) issued in May 2005 outlined the changes/processes required for the implementation of this evidence-based practice. Funding is available for those PIHPs/CMHSPs that initiated this initial system change process as described in the May 2005 RFA. Funding will be targeted for the following treatment characteristics within the IDDT model. The CMHSP must meet the following criteria in order to apply for the areas described in this section:

1. Any CMHSP application must be supported by the PIHP Improving Practices Leadership Team.
2. The CMHSP must work in collaboration with the PIHP IDDT leadership team.
3. The CMHSP must describe how it coordinates each of the proposed activities with the PIHP work teams.
4. PIHP/CMHSP must screen all consumers for co-occurring disorders.
5. PIHP/CMHSP must assess the level of severity of co-occurring disorders and stage of recovery.

6. The treatment plan developed through person-centered planning must address both mental health and substance disorders and ensure the goals and objectives match the consumer's stage of recovery.
7. PIHP/CMHSP must work with the state co-occurring disorder IDDT subcommittee.

Please review the SAMHSA IDDT resource kit before applying for projects to enhance the following treatment characteristics:

- Multidisciplinary Team
- Stage-wise Interventions
- Access to Comprehensive Services
- Assertive Outreach
- Motivational Interviewing
- Substance Abuse Counseling
- Group Treatment

- Self-Help Groups

There is a need for more self-help groups that welcome people with both a mental illness and a substance disorder. People with co-occurring disorders who are in the action stage or relapse prevention stage will benefit from participation in self-help groups designed to fit their circumstances. Models such as Double Trouble and Dual Recovery Anonymous exist. Proposals to assist in the start-up of such local groups may be submitted.

- Peer Support Specialist

MDCH will support the involvement of a peer support specialist with a co-occurring disorder to be involved in the IDDT multidisciplinary team. The peer support specialist must have a co-occurring disorder and have been trained in MDCH sponsored peer support specialist training.

CO-OCCURRING DISORDERS: INTEGRATED DUAL DISORDERS TREATMENET (COD-IDDT), for PIHPs only

Tison Thomas (517) 241-2616 thomasti@michigan.gov

If a PIHP did not apply to implement COD-IDDT in response to the May 23, 2005 RFP and would like to begin implementation of this practice on October 1, 2006, the PIHP may apply for two years of block grant funding for the period of October 1, 2006 through September 30, 2008. For this type of application, use the directions, forms, and requirements of the May 23, 2005 RFP, which is available on the MDCH web site at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health, click on Reports and Proposals. A maximum of $140,000 over the two-year period is available for these projects.

All proposals are due June 26, 2006.

CULTURAL COMPETENCE

Tison Thomas (517) 241-2616 thomasti@michigan.gov

The President's New Freedom Commission on Mental Health report, "*Achieving the Promise: Transforming Mental Health Care in America*" calls for improving access to quality care that is culturally competent. The President's report also stated that the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often undeserving or inappropriately serving them. Culturally competent services are defined as "the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values." Research and data indicates that cultural competence is essential to quality of care, responsiveness of services, and renewed hope for recovery among ethnic and racial minorities. Culturally competent agencies or institutions demonstrate valuing and adapting to cultural diversity, ongoing organizational self assessment, the institutionalization of cultural knowledge and skills and adapting their service to the needs of culturally diverse consumers and their families. Proposals are invited for:

1. Engaging minority consumers and families in workforce development, training and advocacy
2. Recruiting and retaining racial and ethnic minority and bilingual professionals
3. Developing assessment mechanisms and including training curricula that address the impact of wide range of elements including ethnicity, race, country of origin, language, acculturation, gender, age, sexual orientation, religious and spiritual beliefs, socioeconomic class, and education. It also includes consumers' own explanation of the problem in their own cultural terms, perceived causes, specific distress signals, personal and family concept of illness, and how seriously the symptoms are taken within their own world.

For funding, CMHSPs should address possible barriers to care (cultural, linguistic, geographic or economic), provide staffing that reflects the composition of the community being served, and offer training in communication or interviewing skills. CMHSPs must assess consumers' cultural diversity. Some Internet resources for cultural competence include the following:

- National Healthcare Disparities Report (2003)
  http://www.qualitytools.ahrq.gov/disparitiesreport/2003/download/download_report.aspx

- National Center for Cultural Competence (NCCC)
  http://gucchd.georgetown.edu/nccc/

- Cultural Competence Standards in Managed Care Mental Health Services:
  For Underserved/Underrepresented Racial/Ethnic Groups
  http://store.mentalhealth.org/publications/allpubs/SMA00-3457/glossary.asp

FAMILY PSYCHOEDUCATION, for PIHPs only

Judy Webb (517) 335-4419 webb@michigan.gov

If a PIHP did not apply to implement Family Psychoeducation in response to the May 23, 2005 RFP and would like to begin implementation of this practice on October 1, 2006, the PIHP may apply for two years of block grant funding for the period of October 1, 2006 through September 30, 2008. For this type of application, use the directions, forms, and requirements of the May 23, 2005 RFP, which is available on the MDCH web site at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, click on Mental Health, click on Reports and Proposals. A maximum of $140,000 over the two-year period is available for these projects.

All proposals are due June 26, 2006.

HOMELESS

Sue Eby (517) 241-7060 ebys@michigan.gov

Proposals under this category should reflect an ability and readiness to address a homeless population that has demonstrated additional issues of concern, which directly impact their homelessness, such as substance abuse/co-disorder diagnosis. Interventions in this area are intended to address a homeless population who abuses substances and are homeless, those who are homeless and mentally ill, and those who are homeless and have mental illness issues and require assistance in the areas of mental health assessment, detoxification, life skills training, employment opportunities, and coordination of services for the homeless. A housing first approach is recommended.

Proposals are encouraged that promote outreach, integration of mental health and substance abuse services, prevention services, and support services to individuals in stable housing. Under this category, please note that proposals which propose to provide direct payment of rent, security deposits, utilities, etc., for consumers are not acceptable. Proposals should not be duplication of specific PATH grant focus or intent. Proposals in this area should also promote systems transformation and consumer recovery. Applicants are encouraged to link their projects to the 10-year planning process to end homelessness, PATH, MDCH-MSHDA Chronic MDHS Homeless Initiatives, and MDCH-MSHDA Corporation for Supported Housing Projects.

Applicants may wish to consult: Substance Abuse and Mental Health Services Administration. Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. A copy of this publication is available at:
http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp

JAIL DIVERSION

Michael Jennings (517) 335-0126 jennings@michigan.gov

Section 207 of the Michigan Mental Health Code requires all CMHSPs to provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. Jail diversion policies and programs are an important public interest consideration. The department's Jail Diversion Policy defines the conditions for establishing and implementing an integrated and coordinated jail diversion program.

Proposals submitted for jail diversion programs, must utilize The Council of State Government's Criminal Justice/Mental Health Consensus Project Report as the basis for systems transformation and consumer recovery. Proposals must go beyond the basic MDCH contract requirements related to jail diversion and implement aspects of the forty-six (46) policy statements contained in the Consensus Report. Reference material that supports this approach is available from the Consensus Project website at: http://consensusproject.org/pvt/home. The Technical Assistance and Policy Analysis Center (TAPA) provides publications that may be useful to criminal justice and mental health professionals who work with people with mental illness and co-occurring disorders. Their website can be found at www.gainscenter.samhsa.gov.

MENTAL HEALTH CLINICAL SKILLS DEVELOPMENT

Tison Thomas (517) 241-2616 thomasti@michigan.gov

MDCH will support mental health workers in developing clinical skills. CMHSPs could use the block grant for ongoing training and supervision of staff in the following areas:

Substance abuse treatment skills

Clinicians in both mental health and substance abuse treatment settings are not often trained in the other discipline. The availability of staff trained in both fields is limited. The diagnosis and treatment of co-occurring disorders are not generally understood by staff. Funding will be available for case managers to acquire various substance abuse treatment skills.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is a brief form of psychotherapy used in the treatment of adults and children. Its focus is on current issues and symptoms versus more traditional forms of therapy, which tend to focus on a person's past history. The usual format is weekly therapy sessions coupled with daily practice exercises designed to help the consumer apply CBT skills in their home environment.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT) aims to help consumers to validate their emotions and behaviors, examine those behaviors and emotions that have a negative impact on their lives, and make a conscious effort to bring about positive changes. During validation, the therapist helps the consumer see that their behavior and responses are understandable in relation to their current life situation.

OLDER ADULTS

Alyson Rush (517) 335-0250 rusha@michigan.gov

Individuals age 65 and above who have a serious mental illness include the following subsets of hard-to-reach and underserved populations: individuals with severe and persistent mental illness; individuals who may be at risk of committing suicide; individuals who develop depression or another type of mental disorder as the direct result of having one or more co-occurring medical conditions or chronic diseases that require active monitoring and different types of medications; and individuals with a co-occurring mental illness and substance use disorder. Also recognized are adults of any age who have dementia with delusions, dementia with depressed mood, dementia with behavioral disturbances or a co-occurring disorder of dementia with a diagnosable mental illness; and family caregivers of isolated older adults with mental illness or progressive, disabling medical conditions.

Recovery is possible for older adults with mental illness when it involves the concept of hope for an improved quality of life and the concept that people who are mentally ill and also possibly past employment years may still be able to contribute in meaningful ways to their community. Older adults with mental illness incur the double stigma of mental illness and age, which can serve as a barrier to recognizing, seeking, advocating for, and providing for adequate and helpful services and supports. Without school attendance and engaging in the workforce, older adults also have a higher degree of isolation and obscurity, along with their family caregivers. Individuals with a long history of mental illness may develop dementia as they age. Mental health professional staff may not have adequate knowledge of the unique needs of elderly (i.e., sensory loss, multiple medications, loss of natural supports, and dementia).

Proposals must describe the community partnerships developed to meet multiple needs of older adults with mental illness. Identify existing gaps in the community that are particular to this target population and their caregivers (such as access, availability, and quality of mental health services and supports; improved knowledge and skills) and proposed means of closing those gaps and meeting needs. Proposals may focus on replication of a service model that reflects MDCH values, policies, practice-guidelines or other evidenced-based practices, promising practices and emerging practices. Describe how the elderly themselves or caregivers were involved in the planning of this proposal.

More about the mental health needs of older adults is available at the Older Adult Consumer Alliance website: http://www.oacmha.com/

PEER SUPPORT SPECIALISTS

Pam Werner (517) 335-4078 wernerp@michigan.gov

Peer Support Specialists are an integral part of systems transformation at the national level. A natural outgrowth of the 1999 Surgeon General's Report on Mental Health has been the realization of the value of peer-to-peer support in the acquisition of real recovery. Certified Peer Support Specialists provide hope and role model that possibility to every consumer they serve. On February 13, 2006, a bulletin was issued by the Medical Services Administration for the provision of Peer Support Specialists as a b(3) additional service available to Michigan Medicaid beneficiaries who meet the criteria for specialty services and supports. As an additional service each CMHSP is required to offer this service as a choice for individuals during the person-centered planning process. Proposals are requested for hiring and supporting Peer Support Specialists for persons with a serious mental illness. Peer Support Specialists promote hope, personal responsibility, empowerment, education, assist individuals with person-centered processes and self-determination in the communities in which they serve. They share their experiences of their journey of recovery and work directly with individuals to support the recovery process.

The hiring of Peer Support Specialists enhances supports for persons with mental illness that promote community inclusion, participation, independence, and productivity. The Peer Support Specialist works closely in partnership with a case manager/supports coordinator in serving individuals with serious mental illness. The Peer Support Specialist is supervised and supported by a primary case manager/supports coordinator. Some of the activities that Peer Support Specialists can assist with may include: co-facilitate the person-centered planning process; individual budgeting and implementation of the plan; Wellness Recovery Action Plan/Crisis Plan; entitlements, housing, and vocational interests to generate additional personal income; provide ongoing support in connecting people to services and supports in the broader community; and provide support in the area of health and safety as part of the Individual Plan of Service.

Proposals must include:

- How the grantee will recruit, train, and provide ongoing support for Peer Support Specialists and the assigned case manager/supports coordinator, including how each team will be matched to establish partnerships and promote an environment of recovery.
- How work hours and schedule will be determined taking into consideration the needs and wants of the individual and the beneficiaries.
- If the agency will hire peers directly or subcontract.
- If the agency chooses to subcontract, state reasons why.
- How peer(s) will be supported with an office, transportation and use of agency vehicles, name badges, business cards, phone, mailbox, including any necessary supports provided to other agency employees who provide services and supports.
- Training that will be provided to team members on the role of Peer Support Specialists, recovery and the importance of peers sharing their journeys and experiences, use of person first language, team building, mediation and conflict resolution.

- How often peer(s) will receive supervision and mentoring and by whom.
- Funding for up to two years will be considered, depending on the work plan, performance/outcomes resulting in year one funding and documented sustainability of all funded positions.

Peer Support Specialist positions funded will be prioritized in attending the one-week and any follow up trainings at the Ralph A. MacMullen Conference Center in Roscommon, Michigan, with experts from the Appalachian group of Georgia including the follow up testing for certification in Michigan. This training will be funded separately by MDCH; however, travel and incidental meals, and salaries for peers need to be included in the budget. For further information on the role of Peer Support Specialists visit the Georgia website at www.gacps.org

PERSON-CENTERED PLANNING

Pam Werner (517) 335-4078 wernerp@michigan.gov

Proposals to strengthen the practices and processes of person-centered planning must address how the project will assure that person-centered planning is a process not an annual event. Beneficiaries need to be included in the RFP process with significant partnership in the development of the proposal. Proposals can address, the relationship of person-centered processes and recovery, building natural supports, independent facilitation, assisting beneficiaries in carrying out the goals, dreams and desires of the plan etc.

RECOVERY

Colleen Jasper (517) 373-1255 jasper@michigan.gov

A transformed public mental health system will be based on a vision of recovery. A recovery vision is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge. Recovery is a personal journey for each consumer. The belief in recovery for everyone who experiences a mental health problem is essential. The support of recovery in all avenues of the system is critical to enhancing consumers' lives. Consumers developing their own creative way of recovering need to be embraced. Barriers to recovery need also to be addressed. Listening to consumers and their stories is essential in promoting mental wellness and provides a basis of strength that consumers can draw upon.

Applicants are encouraged to review their organization's current capacities to support recovery. Recovery also includes the educational model of training staff, administrators, and consumers. Education allows recovery ideas to be incorporated in all areas of the system. It pulls together the strengths of the system as well as the strengths of the staff and consumers to generate recovery from all angles. Various definitions of recovery, including Mary Ellen Copeland's, can be utilized. All block grant proposals approved by MDCH in the area of recovery need to utilize primary consumers for 80% of their plan with 20% staff that will participate in supportive roles. Several documents that may help you in this effort are attached and include the following:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) unveiled a consensus statement outlining principles necessary to achieve mental health recovery (Attachment D).

- "101 Ways to Facilitate Recovery" from the Office of Mental Health Research and Training, School of Social Work - University of Kansas (Attachment E).

- MDCH's Recovery Council Vision/Mission/Values Statement – This provides a powerful tool to utilize in preparing a response to the creating an environment that is not only supportive of recovery but makes a environment that is actively embracing the components of recovery in all areas (Attachment F).

RURAL INITIATIVES

Alyson Rush (517) 335-0250 rusha@michigan.gov

The department recognizes that both the prevalence and incidence of serious mental illness (the three major categories: Schizophrenia, Affective disorders, Anxiety disorders) occur at similar rates in both rural and urban populations, but that the suicide rate is higher in rural areas (Kessler et al., 1994, "One Healthy People 2010," National Center for Health Statistics 2001). Mental health and mental disorders are the fourth highest ranked rural health concern (Journal of Rural Health 18(1) 9-14, 2002). Rural populations tend to either not recognize mental illness or not perceive the need for care until later than urban populations and tend to be more concerned about costs. In addition, the rural population experiences other barriers (e.g., transportation, age, isolation, substance misuse and unemployment) and a lack of availability of mental health providers, which make accessing care more difficult than in urban areas. This may lead to under utilization of the available service array. Support for staff training in continuing education as well as the development and delivery of evidence-based practices is challenging but critical for rural areas (New Freedom Commission on Mental Health, *Subcommittee on Rural Issues: Background Paper*. DHHS Pub. No. SMA-04-3890. Rockville, MD: 2004. http://www.mentalhealthcommission.gov/papers/Rural.pdf).

The seventy-two eligible counties for rural initiatives can be located on the county list (Attachment G) and are identified as a rural county. Proposals must address the needs of adults who experience serious mental illness, increase awareness of mental health and mental disorders and the availability and successful outcomes of treatment among the rural populations in Michigan. Proposals also may improve the availability and accessibility of mental health services in rural areas and promote the use of evidence-based practices (e.g., Cognitive Behavioral Therapy, Supported Employment, Family Psychoeducation, and enhanced fidelity standards for Assertive Community Treatment, etc.) among mental health providers in rural areas through training or other strategies designed to improve the system. Each proposal must budget travel expenses for one possible regional meeting, either in the Upper or Lower Peninsula that includes travel, meals, and lodging if needed.

SELF-DETERMINATION

Pam Werner (517) 335-4078 wernerp@michigan.gov

The final report from the President's New Freedom Commission for Mental Health called for a fundamental transformation of the behavioral health system. This recommendation rests on two basic principles - that care be consumer and family centered and that it facilitate recovery. The Substance Abuse and Mental Health Services Administration's Center for Mental Health Services and the Center for Medicaid and Medicare Services are partnering together and convened a summit in March 2004 to develop a vision, outline key values and principles, and develop recommendations for an action plan to expand consumer direction in public and private behavioral health services. Michigan supports these efforts and has offered grant opportunities since 1999 in providing self-determination for persons with serious mental illness.

Innovative proposals are requested for applying the principles of self-determination and working toward implementation of the MDCH Self-Determination Policy & Practice Guideline. Proposals for one or two years of funding may be submitted. Proposals must contain:

- documentation that a variety of stakeholders assisted in writing the proposal with the majority (over 50%) being beneficiaries who have a serious mental illness and are currently receiving services through the PIHP/CMHSP;
- how the self-determination principles of Freedom, Authority, Support Responsibility and Confirmation will be actualized and implemented in the initiative;
- how beneficiaries will be offered an array of arrangements that provide a high level of choice and control over defining, selecting, directing and purchasing needed services and supports;
- how knowledge, networking and advocacy will occur for beneficiaries, and their allies in the principles and practices of self-determination;
- changes the current system may need to make to support and facilitate the recovery process;
- the specific mental health service areas in the PIHP/CMHSP will be included in the initiative with a statement from directors/program directors in these areas providing written support for efforts, including the role management and leadership will play throughout the grant period; and
- the valued role beneficiaries will have in the development, implementation and evaluation processes of the grant.

If the proposal contains a request to fund consumer/beneficiaries in the grant, the PIHP/CMHSP must demonstrate that the positions will continue after completion of block grant funding. The agency must address if it has union representation and what support the bargaining units will

have in the continuation of Peer Support Specialist positions in moving self-determined arrangements forward.

Candidates may be requested to participate in a site visit and/or a telephone interview as part of the selection process. Successful grantees will be invited to present at MDCH-sponsored conferences. Travel, lodging and meals need to be included for these activities in the budget.

SPECIAL POPULATIONS

Michael Jennings (517) 335-0126 jennings@michigan.gov

Innovative ideas are encouraged for any special population of persons with serious mental illness, such as women, ethnic minorities, individuals with co-occurring disorders/mental health/criminal justice needs, who may require unique services and supports based on cultural diversity, ethnic diversity, unique barriers or differences not mentioned in any of the other targeted areas. Special population proposals can address any of the aforementioned categories with the emphasis placed on a special population. When submitting a proposal in this category, please note your submission as a special population proposal with another specialty area focus. As with each specialty area, proposals in this area must demonstrate an effort and direction towards systems transformation and consumer recovery.

SUPPORTED EMPLOYMENT

Su Min Oh (517) 241-2957 ohs@michigan.gov

Supported employment is one of the evidence-based practices for people with severe mental illness that have demonstrated positive outcomes in multiple research studies. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) defines supported employment as:

1. Supported employment programs assist people in finding competitive employment – community jobs paying at least minimum wage, which any person can apply for according to their choices and capabilities.
2. Supported employment is a successful approach that has been used in various settings by culturally diverse consumers, employment specialists, and practitioners.
3. Supported employment programs do not screen people for work readiness, unlike other vocational approaches, but help all who say they want to work.
4. Supported employment programs are staffed by employment specialists who help consumers look for jobs soon after entering the program. Extensive pre-employment assessment and training, or intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops are not required.
5. Employment specialists facilitate job acquisition. For example, they may assist with application forms or accompany consumers on interviews.
6. Employment specialists support consumers as long as they want the assistance, usually outside of the work place. Support can include help from other practitioners, family members, coworkers, and supervisors.

The proposals must address how to implement core principles of the supported employment programs:

- *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment.* Employment specialists coordinate plans with the treatment team (e.g., case manager, therapist, psychiatrist, etc.).
- *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- *Job search starts soon after a consumer expresses interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences.
- *Follow*-along supports are continuous. Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Employment specialists will be encouraged and be invited to attend statewide trainings. The training will be provided by MDCH, however, travel, meals and lodging must be provided through the individual agency.

Initiatives **must** include a benefits planning component so that consumers have information about how work activity will impact their ability to maintain benefits. Prior to completing this application, CMHSPs should examine the SAMHSA CMHS website at: http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/ regarding the Supported Employment Implementation Resource Kit. This kit contains copies of research articles and an annotated bibliography, implementation tips for practitioner and mental health authorities, fidelity scale, tools for measuring consumer outcomes, and workbook.

SUPPORTED HOUSING

Sue Eby (517) 241-7060 ebys@michigan.gov

The provision of Supported Housing has been identified by SAMHSA as an evidence-based practice. Housing ranks as a priority concern of individuals with serious mental illness. Locating affordable, decent, safe housing is often difficult, and out of financial reach. Stigma and discrimination also restrict consumer access to housing. Supported housing focuses on consumers having a permanent home that is integrated socially, is self-chosen, and encourages empowerment and skills development. The services and supports offered are individualized, flexible, and responsive to changing consumer needs. Thus, instead of fitting a person into a housing program "slot," consumers choose their housing, where they receive support services. The level of support is expected to fluctuate over time. With residents living in conventional housing, some of the stigma attached to group homes and residential treatment programs is avoided.

Supported housing may benefit those consumers who previously lived in group homes, are diverted from jail, released from the hospital, currently or previously homeless, etc. Proposals are encouraged that promote outreach; education and training; community linkages; coordination with an existing affordable housing collaborative; and support services to consumers. Under this category, please note that proposals which propose to provide direct payment of rent, security deposits, utilities, etc., for consumers are not acceptable. Proposals should not be duplication of specific PATH grant focus or intent. Applicants are encouraged to link their projects to the 10-year planning process to end homelessness, PATH, MDCH-MSHDA Chronic MDHS Homeless Initiatives, and MDCH-MSHDA Corporation for Supported Housing Projects.

TRAUMA

Colleen Jasper (517) 373-1255 jasper@michigan.gov

Statistics show that 80 percent of consumers with a serious mental illness have had some form of trauma in their life. Fifty to seventy percent of all women and a substantial number of men in psychiatric settings have histories of sexual or physical abuse or both. In psychiatric hospitals, 81 percent of men and women who are diagnosed with a variety of major mental health illnesses have experienced physical and/or sexual abuse. Often times psychiatric consumers are then re-traumatized by seclusion and restraints. For many people, Post-Traumatic Stress Disorder (PTSD) is not the presenting problem but, in reality, may be the main disorder.

A trauma-informed system needs to be developed to assist consumers with all aspects of their mental illness. The impact of trauma touches many life domains and is life shaping and dramatic. Education and training as well as the treatment of the symptoms connected with trauma need to be offered.

Trauma is an emerging practice in the State of Michigan; it is a Best Practice Initiative in the State of New York. Attached are two documents that may give you more information regarding trauma (see Attachments H & I). Trauma-informed systems would include the following outcomes:

- a written policy of position paper on PTSD;
- trauma screening and assessment for all individuals coming into the system;
- clinical practice, guidelines, and treatment approaches;
- a collaborative approach to trauma programs with integrated mental health and substance abuse;
- trauma awareness for all staff and consumers;
- a reduction or elimination of seclusion and restraints;
- continuation funding for trauma initiatives; and
- Consumers/Survivors need to be involved in all aspects of a trauma- informed system.

OTHER TYPES OF PROJECTS

Alyson Rush (517) 335-0250 rusha@michigan.gov

There is the expectation that some of the service gaps identified by CMHSPs may not be specifically described in this RFP. Proposals that fit neither the program and/or populations described may be submitted in this category. Please identify the type of proposal under Other on the Face Sheet.

ATTACHMENT A

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration

FY 2006/2007 COMMUNITY MENTAL HEALTH BLOCK GRANT PROPOSAL FACE SHEET

1. CMHSP: _____

2. Program Area(s) and/or Target Population(s) - *check all that apply and please highlight primary area*

___ Advance Directives
___ Anti-Stigma
___ Assertive Community Treatment
___ Case Management
___ Clubhouse Programs
___ Consumer Run, Delivered, or Directed Initiatives
___ Co-occurring Disorders – IDDT
___ Cultural Competence
___ Adults with Dementia
___ Family Psychoeducation
___ People who are Homeless
___ Jail Diversion
___ Mental Health Clinical Skills Development
___ Older Adults
___ Peer Support Specialists
___ Person-Centered Planning
___ Recovery
___ Residents of Rural Areas
___ Self-Determination
___ Special Populations _____
___ Supported Employment
___ Supported Housing
___ People with a History of Trauma
___ Other _____

3. Type of Project Request: ___ 1-Year Proposal ___ 2-Year Proposal
___ Rural County ___ Urban County

4. Proposal Information:

A. Project Title: _____

B. Specific counties to be served: _____

C. Summary of service(s) that will be developed: _____

_____

_____

D. Total amount of Block Grant funds requested: _____

Year 1 Subtotal: _____ Year 2: _____ +50% Minimum Match: _____ = Subtotal: _____

E. Rank this proposal in relation to the total number of requests submitted by your CMHSP:

Rank Order of This Request: _____ Total Number of Requests Submitted: _____

F. Has this program or project been funded previously with Block Grant funds? ___If yes, what year(s)? _____

5. Name and telephone number of the individual(s) **at the CMHSP** to be contacted regarding this application in the event the review panel requests changes that will make the proposal appropriate to recommend for funding. **The budget person must have the authority to modify the budget forms. The work plan person must have the authority to modify the work plan.**

	Name	Position Title	Telephone No.	E-Mail Address
Budget				
Work Plan				

Signature: _____ Date: _____
CMHSP Director

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM			DATE PREPARED	Page	Of
CONTRACTOR NAME			BUDGET PERIOD From: To :		
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT ▶	AMENDMENT #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		

EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)
1. SALARIES & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	$0	$0	$0	$0
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-110

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page Of

PROGRAM	BUDGET PERIOD From:	To:	DATE PREPARED
CONTRACTOR	BUDGET AGREEMENT ☐ ORIGINAL	☐ AMENDMENT	AMENDMENT #

1. SALARY & WAGES POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
			$0
			$0
			$0
			$0
			$0
			$0
			$0
	1. TOTAL SALARIES & WAGES:	0	$ 0

2. FRINGE BENEFITS (Specify)

☐FICA ☐LIFE INS. ☐DENTAL INS COMPOSITE RATE
☐UNEMPLOY INS. ☐VISION INS. ☐WORK COMP AMOUNT 0.00%
☐RETIREMENT ☐HEARING INS.
☐HOSPITAL INS. ☐OTHER (specify) _____ 2. TOTAL FRINGE BENEFITS: $0

3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $0

4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $0

5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Name Address Amount

5. TOTAL CONTRACTUAL: $0

6. EQUIPMENT (Specify items)

6. TOTAL EQUIPMENT: $0

7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

7. TOTAL OTHER: $0

8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	8. TOTAL DIRECT EXPENDITURES:	$ 0
9. INDIRECT COST CALCULATIONS	Rate #1: Base $0 X Rate 0.0000 % Total	$ 0
	Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
	9. TOTAL INDIRECT EXPENDITURES:	$ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)		$ 0

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0386 (E) (Rev 2-05) (W) Previous Edition Obsolete. Also Replaces FIN-11

Use Additional Sheets as Needed

ATTACHMENT C.1

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration

FY 2006/2007 COMMUNITY MENTAL HEALTH BLOCK GRANT PROPOSAL PLANNING SUMMARY

CMHSP_____

(expand document to length needed)

1. Provide a brief description of the CMHSP system of care for adults with serious mental illness (SMI).

2. Identify gaps that are preventing adults with SMI from meeting their recovery goals.

3. Describe how these gaps were identified, and how consumers were involved in the identification.

ATTACHMENT C.2

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration

FY 2006/2007 COMMUNITY MENTAL HEALTH BLOCK GRANT NARRATIVE & WORK PLAN

CMHSP_____

Project Title_____

(expand document to length needed)

Project Narrative:

1. List which gap(s), identified in Attachment C, will be filled in this project.
2. Describe the outcomes that the CMHSP plans to achieve with this project.
3. If the CMHSP is part of an affiliation, describe how this project will fit into the larger work of the Prepaid Inpatient Health Plan to assist adults with SMI in achieving recovery.
4. Detail how other local pertinent community agencies will be involved in the project.
5. Describe how the cultural needs of the specific population(s) to be served in this project will be addressed.
6. For all direct service proposals, describe how the CMHSP will continue this project (50% requirement for the second year and 100% after that) through savings in some other area.

Assure that the project narrative also addresses the review criteria and all other requirements contained in this RFP.

Work Plan:

Attach a project work plan that addresses the full project period and specifies goals, measurable objectives, and specific activities that will be achieved during each quarter of the project period (October 1, 2006 through September 30, 2008 for all direct service projects; October 1, 2006 through September 30, 2007 for one-time purchase/training projects).

Attachment D

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

An Agency of the U.S. Department of Health and Human Services

SAMHSA
News Release

For Immediate Release
February 16, 2006

Contact: Leah Young
Phone: (240) 276-2130
www.SAMHSA.gov

SAMHSA Issues Consensus Statement on Mental Health Recovery

The Substance Abuse and Mental Health Services Administration today unveiled a consensus statement outlining principles necessary to achieve mental health recovery. The consensus statement was developed through deliberations by over 110 expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials and others.

"Recovery must be the common, recognized outcome of the services we support," SAMHSA Administrator Charles Curie said. "This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint. Individuals, families, communities, providers, organizations, and systems can use these principles to build resilience and facilitate recovery."

The 10 Fundamental Components of Recovery include:

• **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

• **Individualized and Person-Centered**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

• **Empowerment**: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

• **Holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education,

mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

• **Non-Linear**: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

• **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

• **Peer Support**: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

• **Respect**: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

• **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov or 1-800-789-2647.

SAMHSA is a public health agency within the U.S. Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment and mental health service delivery systems.

Attachment E

101 Ways to Facilitate Recovery

From "101 Ways to Facilitate Consumers' Recovery Journey"
Office of Mental Health Research and Training
School of Social Work – University of Kansas

Positive Sense of Self

1. Honor each person's uniqueness
2. Use person-first language
3. Raise awareness of internalized stigma
4. Address stigma inside and outside the program
5. Personalize treatment goals and plans
6. Help people explore their strengths
7. Challenge "us-them" mentality
8. Treat no one like a diagnosis

Hope

9. Support recovery role models
10. Share positive information on prognosis
11. Radiate enthusiasm and hope
12. Educate on long-term outcome research
13. Provide recovery autobiographies
14. Peer providers share recovery stories
15. Recovering consumers train staff
16. Consumers work at all levels of the agency
17. Consumer Speaker's Bureau shares hope
18. Help people learn positive self-talk

Meaning and Purpose

19. Assist people to set meaningful goals
20. Honor consumer preferences
21. Offer real choices and options
22. Help people understand their experience
23. Opportunities for people to "give back" to peers
24. Help people define personal and spiritual values
25. Encourage people to set short-term goals
26. Encourage people to risk and grow
27. Help people visualize long-term goals
28. Appreciate each person's potential
29. Encourage "survivors' pride"

Active Consumerism

30. Encourage people to self-direct their recovery
31. Work in partnership with consumers
32. Promote and nurture mutual self-help
33. Fund consumer-run programs
34. Hire consumer affairs officer
35. Consumer voice shapes programs and systems
36. Train, hire and support consumer providers
37. Support consumer advocacy and consumer rights

38. Provide many opportunities for peer support
39. Develop a library of recovery resources
40. Empowerment pervades the program

Wellness

41. Teach self-soothing
42. Assist people to develop wellness plans
43. Educate on diet, supplements and nutrition
44. Link to primary health and dental care
45. Adopt holistic mind/body perspective
46. Educate people on risk behavior
47. Help people heal from sexual and physical abuse
48. Help people to devise a positive lifestyle
49. Provide dual diagnosis supports
50. Help people find joyous exercise

Self-Care

51. Teach people to self-monitor stress
52. Assist people to develop personal coping skills/tools
53. Teach people to self-manage medications
54. Teach relaxation and stress reduction
55. Teach people to self-monitor symptoms
56. Help people identify early warning signs/triggers
57. Teach people to self-control symptoms
58. Teach cognitive strategies
59. Enlist informal social support
60. Help consumers create advance directives
61. Offer consumer-run crisis alternatives
62. Be there when people are struggling
63. Support and respect those not yet in recovery
64. Help people learn from setbacks
65. Run recovery psycho-education groups
66. Celebrate diversity in recovery

A Place in the Community

67. Assist people to acquire affordable housing
68. Help people personalize their home
69. Encourage community exploration/integration
70. Encourage informal community resources and supports
71. Identify options for transportation
72. Link people to community events
73. Heighten community access/challenge discrimination
74. Help people to become involved citizens (e.g., voting)
75. Offer supported volunteering
76. Create empowering niches - consumer-run centers
77. Emphasize social integration in work/housing
78. Offer supported education

Social Relationships

79. Offer supported parenting

80. Encourage membership in community groups
81. Support success in intimate relationships
82. Address sexuality/family planning
83. Encourage people to balance solitude and relationship
84. Help people deepen family support
85. Encourage people to enlist a recovery support team
86. Help people to have pets
87. Support people to develop new friendships
88. Be fully present, authentic, and caring
89. Reach out, support those who are discouraged

Meaningful Activity

90. Inspire creativity
91. Showcase consumer's talents
92. Offer supported employment, including high level jobs
93. Help people request reasonable accommodations
94. Assist people build upon interests/accomplishments
95. Encourage recovery readiness
96. Dismantle boring programs
97. Support spirituality/spiritual community
98. Help people increase assets (barter, self-employ)
99. Tailor activities to unique individuals
100. Celebrate small successes
101. Consumers feel powerful and respected

Attachment F

MICHIGAN RECOVERY COUNCIL

VISION/MISSION/VALUES STATEMENT

VISION

To transform the public mental health system so that recovery is the foundation of the service delivery system for people with mental illness.

MISSION

To transform the public mental health system so that each person can achieve their recovery by:

- **Promoting consumer control, empowerment, self-determination and peer supports.**
- **Promoting partnerships and creating a network of consumers and interested others who will promote the recovery message.**
- **Providing leadership, education, training, and technical assistance on recovery.**
- **Recommending systems, policies and practices that support recovery.**

VALUES (some of these come from the Community Mental Health Services' consensus statement)

We Value:

- **Hope – a system made up of those who give hope and those who receive hope.**
- **The right to pursue and achieve happiness.**
- **Consumers checking on the quality of services and supports provided.**
- **Consumer leadership at all levels of the system.**

- **Self-direction - the belief that one's recovery is unique to one's own journey.**
- **Deciding how our own person-centered plan will be used.**
- **Let consumers be the driving force that conducts their own recovery.**
- **Use of an approach to recovery that includes mind, body and spirit.**
- **A non-linear approach to recovery – the realization that there are periods of ups and downs. Recovery is not a straight journey.**
- **A strengths-based approach to recovery - focusing on our strengths, assets and abilities.**
- **Peer support - the support of sharing with others who are also on the recovery pathway is essential.**
- **Respect for consumers so that self-respect and self-esteem can be developed.**
- **Consumer responsibility - recognizing that consumers are in charge of their own recovery and lives.**
- **Supports for a quality of life of personal choice for each individual.**

5/3/2006

ATTACHMENT G

Rural Counties:

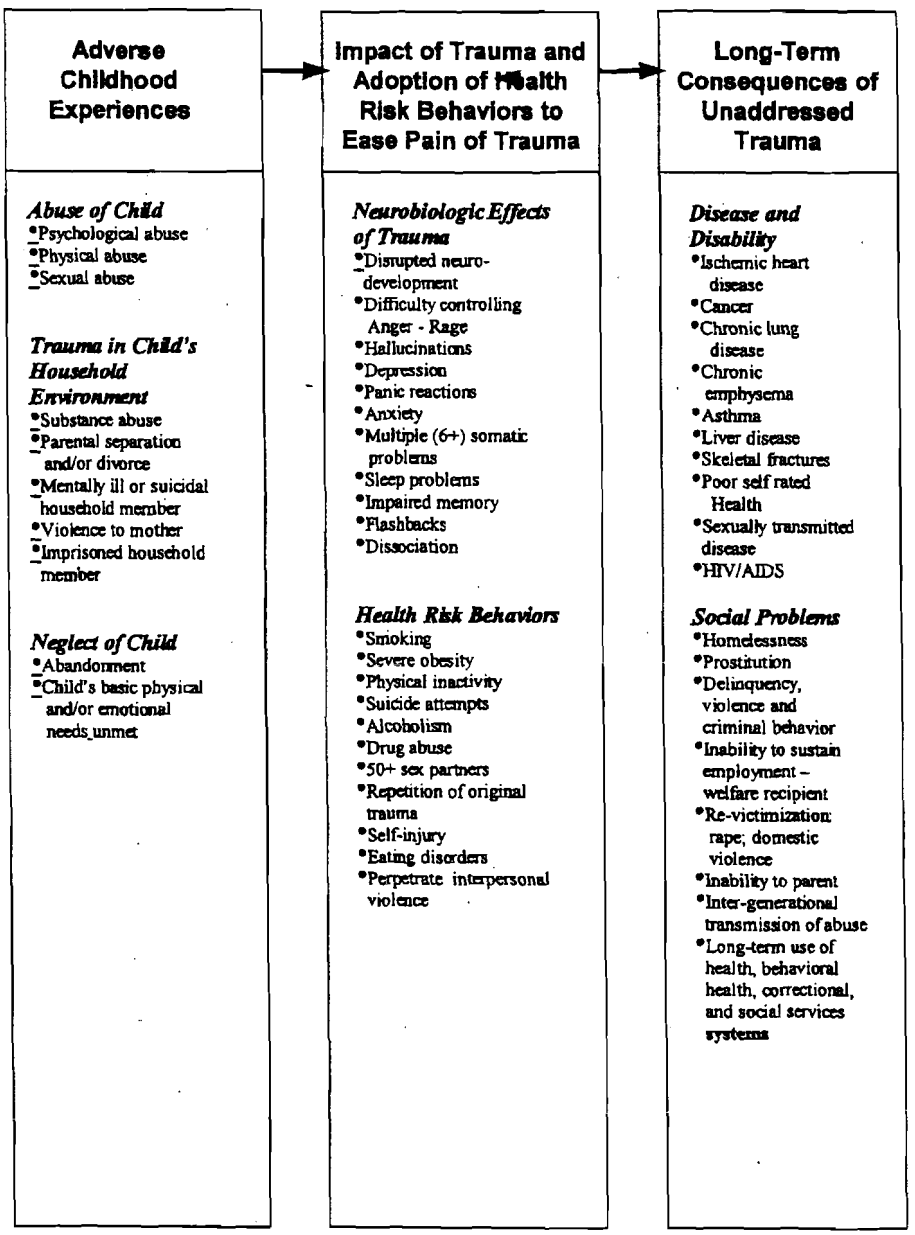
Alcona
Alger
Allegan
Alpena
Antrim
Arenac
Baraga
Barry
Bay
Benzie
Berrien
Branch
Cass
Charlevoix
Cheboygan
Chippewa
Clare
Clinton
Crawford
Delta
Dickinson
Eaton
Emmet
Gladwin
Gogebic
Grand Traverse
Gratiot
Hillsdale
Houghton
Huron
Ionia
Iosco
Iron
Isabella
Jackson
Kalkaska
Keweenaw
Lake
Lapeer
Leelanau
Lenawee
Livingston
Luce
Mackinac
Manistee
Marquette
Mason
Mecosta
Menominee
Midland
Missaukee
Monroe
Montcalm
Montmorency
Newaygo
Oceana
Ogemaw
Ontonagon
Osceola
Oscoda
Otsego
Ottawa
Presque Isle
Roscommon
St. Clair
St. Joseph
Sanilac
Schoolcraft
Shiawassee
Tuscola
Van Buren
Wexford

Urban Counties:

Calhoun
Genesee
Ingham
Kalamazoo
Kent
Macomb
Muskegon
Oakland
Saginaw
Washtenaw
Wayne

Adverse Childhood Experiences and Health and Well-Being Over the Lifespan

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACES) result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission that perpetuates ACES will continue without implementation of interventions to interrupt the cycle.



Data supporting the above model can be found in the *Adverse Childhood Experiences Study* (Center for Disease Control and Kaiser Permanente, see www.ACEstudy.org) and *The Damaging Consequences of Violence and Trauma* (see www.NASMHPD.org). Chart created by Ann Jennings, PhD. www.annafoundation.org

NASMHPD Position Statement on Services and Supports to Trauma Survivors

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that the psychological effects of violence and trauma in our society are pervasive, highly disabling, yet largely ignored. Recent research indicates that interpersonal violence and trauma, including sexual and/or physical abuse over the lifespan, is widespread, has a major impact on a wide range of social problems, and are costly if not addressed. The threat of terrorism is now a constant source of stress for many Americans and the sequalae to recent terrorist events have affected untold numbers of citizens. NASMHPD believes that responding to the behavioral health care needs of women, men and children who have experienced trauma is crucial to their treatment and recovery and should be a priority of state mental health programs. In addition, the prevention of traumatic experiences is a fundamental value held by NASMHPD and its individual members; state mental health authorities. Toward this goal, it is important to support the implementation of trauma-informed systems and trauma-specific services in our mental health systems and settings.[1]

The experience of violence and trauma can cause neurological damage and can result in serious negative consequences for an individual's health, mental health, self-esteem, potential for misuse of substances and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as "difficult to treat"--they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring and are frequent users of emergency and inpatient services.

Trauma is an issue that crosses service systems and requires specialized knowledge, staff training and collaboration among policymakers, providers and survivors. Study findings[2] indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43% to 81%. Studies have

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[1] For purposes of this position statement *Trauma and Traumatic Events* will be defined as the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence (Jennings, 2004; NASMHPD, 2003; Moses, Reed, Mazelis & D'Ambrosio, 2003).

Trauma Informed Care is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services. *Trauma Specific Services* are defined as promising and evidenced based best practices and services that directly address an individual's traumatic experience and sequalae and that facilitate effective recovery for trauma survivors (NASMHPD, 2004).

[2] All statistics cited can be found in *The Damaging Consequences of Violence and Trauma*, compiled by Ann Jennings, Ph.D. NTAC: 2004 and the NASMHPD Curriculum: *Six Core Strategies for the Reduction of Seclusion and Restraint©*, 2004.

shown that up to 2/3 of men and women in substance abuse treatment suffer from posttraumatic stress disorder, acute stress disorder or symptoms; and up to 80% of women in prison and jails were victims of sexual and physical abuse. Children are particularly at risk as over 3.9 million adolescents have been victim of serious physical violence and almost 9 million have witnessed an act of serious violence. Adverse childhood experiences are related to health risk behaviors and adult diseases, including heart disease, cancer, chronic lung disease, skeletal fractures and liver disease. Especially significant for behavioral health care service systems are findings by the National Child Traumatic Stress Network and others that have linked serious behavioral problems to the biological, neurological and psychological effects of violence and trauma in childhood. Early abuse is now believed to create a particular vulnerability to hyper-arousal, explosiveness and/or de-personalization that results in ineffective coping strategies and difficult social relationships.

Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations.

The New Freedom Commission Report Achieving the Promise: Transforming Mental Health Care In America calls for the promise of community living for everyone and for the transformation of our mental health systems of care to meet shared goals that facilitate recovery and build resiliency. NASMHPD believes that the implementation of systems of care that are trauma informed is a cornerstone in building service systems that do not traumatize or re-traumatize service recipients or the staff that serve them. Recovery based services are sensitive to trauma issues and are never coercive. The concept of universal precautions is quite valuable when identifying and implementing the principles and characteristics of trauma informed systems of care to avoid traumatization and re-traumatization.

A set of criteria for building a trauma-informed mental health system were developed at a NASMHPD-sponsored trauma experts meeting in 2003, and a number of state mental health authorities have begun to address the these issues in the public mental health system. Trauma informed prevention strategies adopted by states and service systems include reducing and eliminating the use of seclusion and restraint; the use of prevention tools such as trauma assessments, identifying risk factors for violence or self harm, safety planning, advance directives; workforce training and development; and the full inclusion of consumers and families in formal and informal roles.

Services for trauma survivors must be based on concepts, policies, and procedures that provide safety, voice and choice, and—like all good care—must be individualized/personalized. Trauma services must focus first and foremost on an individual's physical and psychological safety. Services to trauma survivors must also be flexible, individualized, culturally competent, promote respect and dignity, and be based on best practices. Recent research indicates that the most effective approaches for supporting recovery from trauma are well-integrated behavioral health services that also reflect the centrality of trauma in the lives and experiences of consumers[3].

NASMHPD is dedicated to better understanding of the effects of trauma and violence including physical and/or sexual abuse, neglect, terrorism; implementing emerging culturally competent best practices in trauma treatment within the public mental health system; and considering the role of prevention and early intervention programs in decreasing the prevalence of trauma-related behavioral health problems. State mental health authorities are committed to recognizing and responding to the needs of persons with mental illnesses and their families within a cultural and social context. Asking persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives is becoming a standard of care. NASMHPD has taken the lead in recognizing that some policies and practices in public and private mental health systems and hospitals, including seclusion and restraint, may unintentionally result in the revictimization of trauma survivors, and therefore need to be changed.

NASMHPD is committed to working with states, consumers/survivors and experienced professionals in the trauma field to explore ways to improve services and supports for the public mental health service recipient inclusive of trauma survivors consistent with the recommendations of the New Freedom Commission Report. These efforts may include, but are not limited to developing and disseminating information and technical assistance on best practices; supporting research as recommended by the field; providing forums for national dialogues on trauma survivors; consistent advocacy in creating trauma informed and recovery based systems of care; including consumers and their families in the planning, design, implementation and monitoring of best and promising practices; and cooperating with other state and national organizations to develop treatment, prevention and education initiatives to address the issue of trauma.

Original Statement passed unanimously by the NASMHPD Membership on 12/7/98.

Revised Position Statement passed unanimously by the NASMHPD Membership on 1/3/2005.

[3] SAMHSA citation (in press)